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YELLOW FEVER.

In Mexico yellow fever has been present in Merida since August 1, 1911. During this time there have been reported 68 cases with 32 deaths. In San Juan Bautista in the State of Tabasco, there were between May 4 and August 10, 1912, a total of 53 cases of yellow fever with 22 deaths reported. The disease has now made its appearance in Frontera, a port of Tabasco, 55 miles from San Juan Bautista. It presumably was carried from San Juan Bautista by troops transferred to Frontera, where it is reported to be now epidemic. Acting Asst. Surg. J. F. Eaves has been assigned to temporary duty in the American consulate at Frontera for the purpose of fumigating vessels and performing other necessary quarantine work on vessels prior to their departure for United States ports.

In Brazil cases have, during the summer, appeared in Manaos and Pernambuco. In Chile a severe epidemic has occurred at Tocopilla. Cases have also occurred in Colombia. In Ecuador the disease has been present in a number of localities. It has also been reported in Peru at Iquitos, where the disease has been endemic for years. It has also been present in a number of localities in Venezuela.

There are localities in tropical South America and on the west coast of Africa, and undoubtedly also in Central America and southern Mexico, where yellow fever is endemic and has become a disease of childhood. Native adults in these localities usually possess an immunity acquired by infection in early life. The disease, however, exacts a heavy toll among nonimmunes coming from uninfected territory, and these endemic foci are a constant menace to all infectible localities having commercial relations with them.

CHOLERA.

Cholera has been reported on the island of Sardinia. The cases, it is stated, have been confined to the Province of Cagliari, where, from August 14 to 27, there were officially reported 16 cases with 5 deaths. Inasmuch as a large number of immigrants come from southern Italy to the United States, the quarantine officers at the ports at which vessels arrive from there have been notified of the occurrence of cholera and instructed to make careful examinations of all vessels coming from Italian ports.

In Russia, from July 14 to 27, cholera was reported as follows:

The city of Astrakhan, 4 cases; the city of Vitebsk, 9 cases; the district of Vitebsk, 2 cases.

Cholera is also present at Beirut, Syria.

A NOTE ON ACID-FAST BACILLI IN HEAD LICE (PEDICULUS CAPITIS).

By George W. McCoy, Passed Assistant Surgeon, Director, and Moses T. Clegg, Assistant Director, Leprosy Investigation Station, United States Public Health Service, Honolulu, H. T.

Several observers have reported the presence of acid-fast bacilli in various insects taken from lepers. With the exception of Ehlers, Bourret and With[1] who report doubtful organisms of this nature in a louse which had fed on a leproma four and one-half hours previously, the results with these insects have been negative.

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[1] Ehlers, Bourret and With, "Rapport d'ensemble sur les travaux de la Mission dano-francaise d'etude de la Lepre aux Antilles danoises 1909," Archiv fur Dermatologie und Syphilis, vol. 106, p. 193.

In some recent work in connection with the study of the possibility of the transmission of leprosy by animal parasites, we found a large number of acid-fast bacilli in smears made from two lice (*Pediculus capitis*) taken from an advanced case of nodular leprosy. In morphology, grouping, and tinctorial characteristics, the organisms found in these insects were indistinguishable from the leprosy bacillus. There was a leproma on the forehead adjacent to and invading the scalp. It is well known that the invasion of the scalp by the lesions of leprosy is rare.

We have examined lice from several other cases of leprosy but with uniformly negative results.

ROCKY MOUNTAIN SPOTTED FEVER.[1]

By W. C. RUCKER, Assistant Surgeon General, United States Public Health Service.

HISTORY.

For over a decade Rocky Mountain spotted fever has been a problem of great interest to the physician, the zoologist, and the sanitarian. Its geographic limitation, seasonal prevalence, intimate association with wood ticks, and variation in severity in different localities combine to make it one of the most interesting and intricate disease problems which have arisen in our generation. It has a peculiar interest, because apparently it is confined to the American Continent, and it has therefore been considered appropriate to present a brief review of the progress in the study of the disease and to indicate the lines along which investigative and eradicative work should be carried in the future.

Although the disease has been known in Idaho and Montana since 1873, the first specific reference to it in literature is to be found in the report of the Surgeon General of the Army for the fiscal year ending June 30, 1896 (77). It is there stated that "the surgeon[2] at Boise Barracks referred in one of his monthly reports to the prevalence of spotted fever in the civil settlements in the neighborhood of the post. On being requested to give fuller particulars concerning this fever, he stated that as he had not seen any of the cases that occurred he had called upon his medical friends in civil life for information." These gentlemen (Drs. C. L. Sweet, W. D. Springer, R. M. Fairchild, L. C. Bowers, J. K. Dubois, D. W. Figgins, and H. Zipf) responded promptly and their reports constitute the first published accounts of Rocky Mountain spotted fever as a disease entity.

It was not until 1899, however, when Dr. E. E. Maxey, of Boise, Idaho, read a paper entitled "Some observations on the so-called spotted fever of Idaho" (32), before the Oregon State Medical Society, that the disease began to attract any wide spread attention. This lucid paper expresses the opinion that spotted fever is a specific disease and gives an accurate description of its clinical manifestations.

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[1] This paper originally appeared in the Military Surgeon, Vol. XXIX, No. 6, Dec., 1911, pp. 631-657 under the title, "The problem of Rocky Mountain spotted fever." As republished here the text and bibliography have been amended so as to cover the subject to the present time.

[2] Then Capt. (now Lieut. Col., Deputy Surg. Gen., retired) Marshall W. Wood, M. C., U. S. A.